STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 62040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations	S9999		

State Licensure Violations:

300.1210b)5)
300.1210d)6)
300.1220b)3)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on record review and interview, the facility failed to supervise toilet use for 2 of 5 residents (R2 and R5) reviewed for falls in a sample of 21. This failure resulted in R5 falling and sustaining a

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fracture of the left hip.

The findings include:

1. R5 is a 93 year old female. The Physician's Order Sheets (POS), dated 10/2015, document in part, that R5 has a diagnosis of dementia, general pain and osteoarthritis.

R5's Minimum Data Set (MDS), dated 09/23/2015, documents R5 required extensive assistance for transfers, was not steady, only able to stabilize during transfer and moving on and of the toilet with staff assistance, did not walk and used a wheelchair. The MDS documents she has severe cognitive impairment.

R5's Care Plan, dated 10/30/2013, document in part, that R5 is at risk for falls related to impaired mobility, impaired safety awareness, use of psychotropic medication, history of falls prior to placement and diagnosis of dementia.

The Facility Incident Report, dated 10/26/2015, documents R5 had a fall on 10/26/2015 at 4:51 PM. The Report documents "Resident complained of pain following fall, x-ray at hospital performed revealed fracture. Final Investigation will follow. Administrator notified 10/26/2015 at 5:45 PM, Medical Doctor notified 10/26/2015 at 6:00 PM, Family Notified 10/26/2015 at 6:05 PM."

The Facility's Post Incident Actions with an Incident date of 10/25/2015, at 7:40 PM, documents in part, "(E4, Licensed Practical Nurse,LPN) was assisting another resident in his room at which time the nurse was notified that (R5) had fallen in her room. (E4) went into (R5's) room upon entry nurse found (R5) lying on her floor. (R5) stated that she was unaware that she

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could not walk by herself at that time (E4) assessed (R5) no bruises or injuries at this time. Resident was assisted to her bed. Resident denies any pain or discomfort at this time. Resident room well lit. Resident room free of clutter. Will continue to monitor." R5's Care Plan was not revised after this fall.

There was no documented entries on 10/25/15 in R5's Nurse's Notes which was the date of R5's fall.

The first Nurse's Note regarding the fall is dated 10/26/2015 at 3:19 PM, documents in part," Resident currently on Instruction Follow Up (IFU) in relation to a fall. Resident had complained about left hip. Resident has bruising to left elbow and reddening to left hip area. Writer placed call to general medicine and received order per phone for a bilateral hip x-ray. The next entry in the Nurse's Notes, dated 10/26/2015 at 6:37 PM, document in part, "At around 7:40 PM, (E4) was alerted by (E5), Certified Nursing Assistant (CNA) that (R5) had fallen. (E4) went into (R5) room. Upon entry found (R5) lying on floor. Resident had no bruises or injury. Resident was offered ice. Resident refused. Resident was offered pain medication resident denies any pain or discomfort. Resident states she is sorry about what happened she forgot she could not walk by herself." The following Nurse's Note, dated 10/26/2015 at 8:04 PM, document in part, "Resident x-ray results obtained resident has fracture to left hip. (R5) transported to hospital."

The x-ray report, dated 10/26/2015, documents in part, (R5) sustained a fracture involving the left femoral neck with modest displacement.

The Facility's Final Incident Report, dated

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10/27/2015, documents in part, "(R5) was attempting to ambulate without assistance when she lost her balance landing on her left side. Charge nurse assessed (R5) for injury. Physician made aware of the incident. On 10/26/2015 (R5) had redness noted to left hip with bruising and complaints of low groin pain. (R5) was assessed with new orders for an x-ray to hip."

On 7/21/16, at 1:00 PM, E2, Director of Nurse's, stated R5 had only one fall resulting in a fracture which occurred on 10/25/15, not 10/26/15 as documented in the Facility Incident Report. E2 said this was a documentation error.

On 07/21/2016 at 9:00 AM, E4 stated "(E5) was toileting (R5) in her room. I was in the hallway with another resident who was leaving the dining room. The other resident's knee began to buckle and I yelled out for help. (E5) immediately came to assist me. (R5) was left alone in the toilet. (E5) went back into (R5's) room and found her on the floor. I then went into the room and found (R5) on the floor. I assessed her and there were no bruises or injuries and we put her back to bed. My shift was almost over I work 7 PM-10 PM and I left."

On 07/21/2016 at 9:18 AM, E5 stated "I was toileting (R5) when I heard (E4) calling out for help. I left (R5) alone (she was on the toilet) to help (E4). When I came back into (R5's) room I found her on the floor. I came and got (E4). Yes, (R5) was complaining about pain. We eventually got an x-ray and (R5) had fractured her hip. (R5) was complaining about pain in her hip after she fell."

On 07/20/2016 at E7, CNA stated "Yes, I remember (R5) falling. She was trying to go to the

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bathroom she was ambulating and fell. Yes, she was complaining of pain right away. I believe she broke her hip."

2. R2's Physician Order Sheet (POS) dated 07/01/16 documents R2 has diagnoses of Dementia and Alzheimer's.

R2's MDS, dated 06/29/16, documents R2's balance moving on and off the toilet is not steady, and she is only able to stabilize with staff assistance. R2's MDS also documents R2's balance moving from surface to surface is not steady, and can only be stabilized with staff assistance. R2's MDS also documents R2 needs extensive assistance with a one person physical assist for toileting.

R2's Care Plan, dated 03/2016, documents R2 has a personal history of falls. The Care Plan documents R2 uses an alarming self releasing belt while up in a wheelchair.

R2's Nurse's Note, dated 07/04/16, at 10:42 AM documents E19, Certified Nursing Assistant (CNA) responded to a call light, and observed the resident sitting upright on the floor of the rest room.

R2's Resident Incident Report, dated 07/04/16, documents R2 was trying to toilet herself, E19 went into the restroom, when E19 observed resident sitting on the floor.

On 07/21/16 at 8:50 AM, E19 stated "(R2) fell on the Fourth of July. I had taken her to the bathroom, and put her on the toilet. She asked for brief privacy. I heard someone else call out, and I went to check. The other resident wanted to go to

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S9999	Continued From page 6 the toilet, and I told her I would be back. When I reentered the room (R2) was sitting on the floor with her pants up." On 07\22\16 at 1:45 PM, E1, Administrator stated "If the resident is Care Planned to need assistance, unless there is an emergency they should be near by to help." (B)	S9999		